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Costs, Payments, and Incentives in Family Planning Programs

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Countries differ in whether they charge clients for different forms of birth control, offer them free, reward people for using them, or penalize people for not using them.

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Governments in developing countries — concerned about rapid population growth and the rising costs of family planning programs — face difficult ethical and practical considerations in deciding how to recover costs yet stimulate family planning.

Policies vary widely. Sri Lanka, for example, charges for pills and condoms, offers IUDs and injectables free, and pays the acceptor for sterilization.

Pakistan and the Republic of Korea charge for resupplies of pills, condoms, and spermicide and pay the acceptor for sterilization. Bangladesh and Nepal give resupply methods free and pay the acceptor for sterilization (and, in Bangladesh, for using the IUD).

Turkey, on the other hand, charges for sterilization but provides IUDs, pills, condoms, and diaphragms free. Jordan charges for the IUD and offers the pill free.

Some countries offer community incentives for achieving family planning goals. Some offer families incentives for remaining small. Several countries, especially in Asia, impose penalties on families that exceed the norm.

What practical and ethical considerations shape these policies? This paper reviews current practices and policies in developing countries and considers the ethical issues that each kind of incentive and disincentive raises.

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by
John A. Ross and Stephen L. Isaacs

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The financing of health care and family planning programs has become a matter of international concern as national budgets for social services have been reduced while demands on those services have increased (Abel-Smith, 1985; Arellano, 1987; and Cornia et al., 1988). Cost pressures grew with the oil crisis of the 1970s and the debt crisis of the 1980s, and foreign aid from developed countries has declined in real value. Where public funds are diminishing, concern has been raised as to the source of support for "Health for All by the Year 2000" and for family planning programs--either as part of or separate from the health sector. This concern has led to suggestions that user fees be instituted or increased--at least for those who are able to pay, that communities play a greater role in providing services, and that the private sector be more involved in the provision of services (World Bank, 1987).

However, where family planning is concerned, issues other than cost are involved. The threat of rapid population growth is so great in some countries that economic rewards are offered to encourage couples to have fewer children or to adopt contraception or sterilization. Other countries consider it a basic human right--akin to the right to health care--to have the number and spacing of children desired, and they provide contraceptives free to enable people to enjoy that right.

Thus, a variety of monetary policies regarding contraception exists around the world. These range from high user charges in some countries, to free contraceptives in many, to incentives and disincentives in others. This paper examines these policies, focuses on charges and payments as they existed in early 1988, looks at the consistency of monetary policies within countries, and considers the ethical issues raised by each kind of incentive.

Data

The data in this paper come principally from a 1987 questionnaire inquiry to the 100 developing countries having populations over one million. At the time of this writing, responses were in from 65 countries, with most nonresponses concentrated in the countries with the least programmatic activity, chiefly in Africa and the Middle East. A large amount of secondary data has been used to supplement the survey, including information from a historical series created by Nortman (1985 and prior years), beginning in 1969 and containing data through 1983. Nortman's data have never been computerized or aggregated into a single time series; we have done that and have combined it with another historical series for sterilization information (Ross et al., 1985). Our questionnaire updates both series for 1984 onward and adds a few additional variables.

A Typology

Since considerable confusion exists in defining cost measures, we begin with a basic typology. The distinctions made here are observed throughout the paper.

First, payments are made to: (a) acceptors, (b) providers, and (c) recruiters, all focused on the act of accepting a method (usually sterilization). These payments may be in cash or in kind and are usually given immediately upon acceptance. They vary in amount, and on this variation rests much controversy. A small payment merely replaces out-of-pocket costs and thereby removes a barrier, whereas a large payment can be a strong inducement to an act that would otherwise not have occurred

or would have occurred later. In between is an ambiguous zone, complicated by the fact that a fixed payment may be trivial to some but significant to others. Payments, when small and trivial, are not properly termed incentives. Some payments and gifts, on the other hand, have clearly been large enough to act as true incentives, and have been intended to do so.

A second category is the opposite of the first--charges to the client for contraceptive supplies and services. Subtypes exist according to whether the context is a public program, a social marketing scheme, or the commercial sector.

Third are "community incentives"--inducements offered to units small enough to have a sense of group identification. These are directed, for example, at a mothers' club, a village, or a local administrative area--again, one small enough to possess the basic sense of community. Some incentives involve rewards only to the group, such as a new well or irrigation system; others offer rewards to individuals but are still given under community auspices and influence. Such measures take various forms and have occurred mainly in pilot projects, although China and Indonesia have implemented them on a national scale.

A fourth type of cost measure consists of incentives and disincentives directed at the general population (as distinct from small groups). These are oriented directly to fewer births, as distinct from inducements to practice contraception. Some involve benefits (or penalties) tied to the nth child: salary level, tax exemptions, maternity leaves, eligibility for preferred housing, schools, and so forth. These have been used chiefly in Asia, but tax and maternity measures appear to a surprising extent in other regions as well.

Charges and Payments for Contraceptive Use

Public Programs

Depending upon the country and the method, the person adopting contraception through a family planning program may have to pay for it, may get it free, or may receive a payment[1] from the program.

Most programs about which we have information provide methods free, especially in Africa, as shown in the middle column of Table 1. While most African countries with public programs probably do give contraceptives free, many of the program efforts are weak and their coverage is limited. Other programs charge the acceptor (column 1), though usually a small amount.

Still others pay the acceptor. In Asia, six programs pay the acceptor for sterilization (column 3), even though they charge for other methods or give them free. Bangladesh also pays IUD acceptors, as does India. We know of no program that pays the acceptor for any other methods.

How consistent are countries in their charges or payments for the various methods? Many, in fact, treat different contraceptive methods differently. Although some policies appear inconsistent and highly varied on the surface, they may reflect conscious policy decisions. For example, a country that wants to encourage sterilization might offer incentives for the procedure and, at the same time, provide other contraceptives free of charge or even at a small cost. Some inconsistencies, however, have no apparent rationale.

Countries that are consistent in that they offer all methods free (to the extent that they provide them at all) include Chad, Ethiopia,

Liberia, Niger, Nigeria, Sudan, Togo, and Zimbabwe in Africa; China, Indonesia, and the Philippines in Asia; Colombia, Costa Rica, Jamaica, Mexico, and Paraguay in Latin America; and Egypt, Morocco, and Tunisia in the Middle East. Some countries or economies are consistent in the other direction, by charging for every method that they offer; these include Botswana in Africa, Hong Kong and Taiwan (province of China), in Asia, and Peru in Latin America (where there is a small standard charge for all Ministry of Health services; no charge for social Security Services).

Countries with inconsistent cost structures fall into the various possible types:

o Sri Lanka charges for orals and condoms, offers IUDs and injectables free, and pays the acceptor for sterilization.

o Pakistan and the Republic of Korea charge for resupply methods (these include orals, condoms, and spermicides) and pay the acceptor for sterilization. (Korea also provides menstrual regulation free to low-income women, and charges for the IUD.)

o Bangladesh and Nepal, on the other hand, give resupply methods free (as well as injectables in Bangladesh), and pay the acceptor for sterilization (and for the IUD in Bangladesh).

o Turkey is unusual in charging for sterilization, while providing IUDs, orals, condoms, and diaphragms free. Jordan charges for the IUD and offers the pill free.

Thus, every pattern is represented. Two countries fall into all three columns of Table 1 (Korea and Sri Lanka), and at least two countries fall into every combination of two out of the three columns. Moreover, nearly every method is offered free in some country, and is provided for a

fee in others.

What then can explain these various inconsistencies? The apparent reason that certain countries in Asia make payments to sterilization acceptors is that this method involves only a single act and has a permanent demographic effect. Payments also take into account that sterilization is exceptional because it involves a period of reduced work activity. Some countries no doubt charge for the pill because they incur fairly large costs for the resupply and logistics involved; this is often true for condoms as well. Certain inconsistencies can be explained by the donor practice of giving some commodities free but not others. For clinical methods, sometimes the attempt is to recover some medical costs. In other cases the rationale is to make all methods free to encourage their use. On the contrary, some countries may charge for all services on the grounds that free services are not appreciated. Different countries take different positions on the various methods. Some are too poor to have much choice; the Ghana government has felt that it cannot afford to give free services, and so has instituted small charges for contraceptives and minor health commodities. On the other hand Thailand removed charges for oral contraceptives, largely to help meet its demographic targets.

What are the amounts involved, for charges or payments to acceptors? As seen in Figure 1, the pill is provided either free or at a price up to US$.60 equivalent, and is almost always sold for well below the commercial price in the same country. Higher charges for oral contraceptives are made in Ethiopia and the more economically advanced Asian economies of Hong Kong, Taiwan (province of China), and Singapore. For the IUD, as seen in Figure 2, the highest charges occur in Jordan, Singapore,

and Hong Kong. (Note the small payment made to the IUD acceptor in Bangladesh and India.) Sterilization charges (Figure 3), where they are made at all, are of course higher than those for any other method. The small charges in Turkey and Singapore are exceptionally low, and sterilization is free in Morocco and Mexico. Among the countries in which a payment is made to the acceptor of female sterilization, Korea is a special case: a large payment is made to low-income acceptors of sterilization. Acceptors receive US$45 if they have more than two children, $110 if two children, and $330 if one child. These amounts are somewhat less significant than they may appear given the relatively high per capita income in Korea, but they are offered only to persons of low income. The other countries make smaller payments to the sterilization acceptor, but such payments gain importance against the background of the acceptors' lower per capita incomes.

The charges for vasectomy (not shown) are less than those for female sterilization in Taiwan (province of China) and Hong Kong, but for the other countries or economies shown the charges are essentially the same, even though the real cost of vasectomy is a good deal less than that of tubectomy.

Provider Payments

Some programs also pay the provider a per-case fee, which may encourage higher acceptance rates. The regional pattern for provider payments appears in Table 2.

The African countries all fall into the first column, making no per-case payments at all. On the other hand, some Asian countries do make such payments, and they do so to all categories of family planning

personnel. Most Latin American and Middle Eastern countries make no payment to providers. None of them appears in the sterilization column, perhaps chiefly because of strong feelings against sterilization payments.

Burma, Laos, Hong Kong, Singapore, and Thailand, in Asia, do not pay providers on a per-case basis, nor does the much different Chinese system. However, other Asian countries pay some or all providers for various methods. In general, the same Asian countries that pay the client for sterilization also pay the providers on a per-case basis, and these tend to be the very large or densely populated subcontinent countries. Where provider payments exist, the physician is nearly always paid for sterilization, IUD insertion, and the provision of the pill--except in Taiwan (province of China), where, for IUD and sterilization cases, only the fieldworkers are paid. The nurse or midwife is also often paid for all three methods, as are the "other" personnel (usually a fieldworker of some type). Unfortunately, the available data do not clearly designate recruiters except in the "other" category, but Bangladesh and India are prominent among the few countries that have tried making per-case payments to recruiters of various types. Countries that pay providers at all pay not just one but generally two or three of the different personnel categories.

The amounts paid to providers are quite modest, for the most part. However, the equivalent of US$5 in Nepal and even US$.60 in Bangladesh to the physician for tubectomy are said to have a motivating effect as cases accumulate over a month or more, and certainly each amount must be judged within its own cultural context.

Providers who receive incentives may also include officials and administrators (who are "providers" only in an indirect sense). They may be

given quotas for numbers of acceptors, sometimes separately for each method, or targets for total prevalence of contraceptive use. Promotions, transfers, and salary raises may depend partly upon meeting targets. From one standpoint, these goals are no different from the expectations in many public and private enterprises. However they may develop into very strong pressures especially when they are combined with incentives offered to individuals.

We turn now to the charges for contraceptive supplies in non-program settings. Charges within three contexts were mentioned at the outset: public programs (covered in the preceding section), social marketing plans, and the commercial sector. The latter two now follow.

Social Marketing Plans

We included in our questionnaire a few items on social marketing programs,[2] and obtained estimates of prices from that and from other sources. The results appear in Table 3. It should be borne in mind that the programs vary greatly in character and in their manner of subsidizing contraceptive products. Some channel products chiefly to private doctors, others to retailers. Some use nonprofit agencies and others only the purely commercial sector. The plan of Taiwan (province of China) works only through factories; in Colombia (not shown) one plan involved sales to private doctors, through orders by mail.

Large differences in price also exist for the same contraceptive method, even within the same country. Two- and three-fold differences within countries appear for the condom in Bangladesh, Sri Lanka, Thailand, and Mexico, and large differences exist in the price of orals, as well.

Across countries the variation is even greater--for example, from US$.08 to US$5.16 for a dozen condoms, and from US$.11 to US$1.26 for one cycle of the pill. Some of these variations reflect quality differences, as with condoms; some reflect product procurement from different sources--for example, international versus local manufacturers; and some reflect a variety of other causes.

The Commercial Sector

We now turn to commercial prices, paid in the marketplace for resupply methods, or paid to private doctors for sterilization or the IUD. (Minimum prices are used in this discussion to avoid the complexity of dealing with ranges, and because the mass of poor consumers will usually gravitate to the low price. The figures that follow use the only price given when a country did not report a range.)

The outstanding feature of commercial prices is their vast range across different countries, even within the same region. One cycle of the pill ranges from less than US$.05 to over US$4 (Figure 4). The IUD (Figure 5) costs from less than US$.17 (in Indonesia) to over US$70, and up to US$150 in Puerto Rico and US$300 reported for one African country, Cote d'Ivoire. The same extreme variation appears for the other methods, whether clinical or not--private sector sterilization costs (Figure 6) vary widely, as do condom prices (not shown), up to US$5 to US$6 or more per dozen.

These differences no doubt reflect duty charges, high prices due to scarcity, and other factors. In Africa, of course, costs to the consumer relative to the average income are comparatively greater than in those Asian countries where per capita income is much higher.

To summarize, these data furnish new information on the costs of contraceptives in public family planning programs, in social marketing programs, and in the commercial (private) sector. They also cover the payments made for contraceptive adoption to both clients and providers. There are very large differences among countries, and very different forces that govern the decisions of how much to charge, or pay, for different methods.

Community Incentives

Community incentives are intended to create a sense of social responsibility within the group to practice family planning. In both China and Indonesia local government units have been given goals and offered benefits or prizes for the best performance records. In China the local employment unit bears most of the responsibility for making the promised payments to one-child families. In Indonesia loan funds have been given to acceptor clubs to manage; loans can go to any community member but club members manage the fund and so gain prestige. In India several states have offered awards to village councils. The awards range from cash to a bag of cement for each vasectomy performed. In 1983 the Indian government announced an expanded program of benefits to community groups, manufacturers, and labor unions to reward contraceptive performance. In 1983 the Bangladesh government announced that it would begin to give cash awards to districts that achieved family planning goals (but these may never have been implemented, and in any case districts are too large to possess a sense of community).

A recent community incentives pilot program in Thailand tied

family planning incentives to a village revolving loan fund (Weeden et al., 1986). In this plan, the villages received a US$2,500 loan fund; family planning users were allowed to apply for larger loans than nonusers, shares in the fund's profits from interest were larger for those who used more effective family planning methods, and additional grants to the village were predicated upon an increase in contraceptive prevalence.

Incentives and Disincentives for Small Families

Incentives to have small families go beyond a one-time payment for adopting sterilization or an IUD. The objective is not to remove barriers to contraceptive acceptance or to induce people to accept a specific method, but, rather, to create the motivation to limit family size by providing advantages to families who have few children and/or punishments to those who exceed a specified number.

This approach is used most extensively in China and the smaller states of East Asia. In Singapore, the first three children get a choice of schools and, until recently, parents having two children or less got priority for government flats. In China, where the government is promoting the one-child family, benefits are the largest and most varied, and they differ considerably from province to province. In general, children in one-child families receive priority in health care and in admission to schools, and their parents are eligible for improved housing, better jobs, an additional monthly stipend, more land, and eventually higher pensions. In Indonesia a generous monthly rice allowance is given to every government employee for every family member, but only through the third or fourth child. In the Republic of Korea, families with two or fewer children

receive preference for medical care and public housing, and older people who have only two children receive higher pensions. (In addition, as mentioned above, payments are made to low-income people who choose to become sterilized.)

A great deal of ingenuity has been shown in devising ways to benefit parents of small families. For example, in India in the early 1970s, a no-birth bonus scheme was devised for workers on the tea estates. A payment was made into a savings account for each month of nonpregnancy. The account was redeemable, with 5 percent compound interest, at the end of the woman's childbearing years. However, 50 to 100 rupees were to be forfeited if the woman had a third child, 250 if she had a fourth child, and the entire account cancelled on the birth of a fifth child (Ridker, 1971). Similarly, in a small pilot trial in Taiwan (province of China), families with two or fewer children had money set aside that was later redeemable for the education of their children. Of course one of the problems with long-term benefits is that they require couples to plan for the future and have confidence that the government or business will deliver on its promises, and this can rarely be assured.

Disincentives

A number of countries, particularly in Asia, have imposed penalties on families with more children than the established norm. In China, provinces have used disincentives on families that have more than one child, though we understand that these have applied only to those who signed the one child pledge. Among these disincentives are loss of health benefits, reduced priority in school, and return of benefits previously

accrued. During the 1960s and 1970s Singapore enacted a wide ranging program of disincentives which includes maternity fees that escalate with parity, lower priority in choice of schools for fourth- or higher-order children, and, until recently, reduced priority for government housing. During the 1970s, Indian civil servants who failed to reach their quota of sterilization acceptors were threatened with loss of benefits. Recently, the National Planning Commission of Bangladesh announced that upazilas (subdistricts) that failed to meet nationally established family planning targets would have their development budget cut by 5 percent.

A relatively common disincentive is to limit the number of tax deductions for children. Kenya, for example, permits tax deductions only for the first four children. Tax deductions for children have been completely eliminated in Nepal, Sri Lanka, and Tanzania. Some countries--for example, Cameroon--that pay child allowances limit them to a certain number of children. For example, Tunisia gives a family allowance to parents only for the first three children. Similarly, at least eight countries-- including Ghana, Singapore, Republic of Korea, and Thailand--limit maternity leaves to a specified number of births.

Ethical Considerations

Payments and incentives to encourage contraceptive use and small families raise a number of ethical issues. We therefore reexamine here each category of measures defined at the outset to consider its ethical features. First, however, some general remarks are needed as background. Some observers consider incentives inherently coercive, reducing freedom of choice by offering irresistible rewards or pressures. Others respond that

moderate, positive incentives shift the balance of costs and rewards and so serve to increase freedom of choice, particularly for poor people. The range from the simple relief of out-of-pocket costs to the application of powerful incentives is a matter of degree, and persons of different incomes are affected differently. The ethical judgments, therefore, become shaded, inviting the very contentiousness for which the incentives question has been so widely noted.

A crucial aspect of the ethical dilemma is found in the tension between a government's proper function of protecting the welfare of current and future generations, versus the right of individuals now alive to freely determine the size of their families. This tension is clearly reflected in a well-known paragraph of the World Population Plan of Action (United Nations, 1974):

> All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community (Isaacs, 1981:369).

The contradictions are apparent: couples and individuals can decide "freely," but also "responsibly," and in light of other "needs." As with most other human rights, the fact that people have the right to determine the number and spacing of their children, does not mean that the government can never infringe it. The question is under what circumstances,

and in what ways, government can ethically take action: in this case, to reduce childbearing where it perceives that the well-being of the community or of future generations is endangered.

With regard to incentives, three principles may provide some guidance. First, the right of couples and individuals to determine the number and spacing of their children takes general precedence. Infringements on voluntarism must be justified by a substantial demonstration that reduction of population growth is urgent and necessary. Governments can ethically attempt to restrict childbearing by means of incentives and disincentives only in those cases where continued high fertility rates threaten the well-being of the society with severe harm to present or succeeding generations. Some indicators of severe harm are clearer than others. Candidates include malnutrition or starvation, widespread depletion of natural resources, and such extensive unemployment that the fabric of society is threatened. Second, governments should apply those measures that respect voluntary choice before moving to more restrictive measures. Although this principle of gradualism is easy to state, in practice it may be difficult to weigh the restrictiveness of various measures, particularly when incentives are used in combination with one another.

Third, any measure that penalizes children for being the nth child should be avoided. This follows from the basic ethical principle that innocent people should not be penalized for the behavior of others. It is buttressed by the rule that children should not be harmed if it can be avoided. Most specifically, children should not suffer by the accident of having been born later than their siblings. Measures that deprive children

of health, educational, or other benefits solely because they are the second or third child are objectionable. How, then, do the incentives examined above fare regarding ethical standards? We now cnosider each of the types set forth at the outset.

Acceptor Payments

The extent to which monetary or other payments infringe upon the principle of voluntariness depends, in large measure, upon the payment amount in relation to the income level of the recipient. The early payments for sterilization in India and elsewhere were justified conceptually as compensation for time lost from work, transportation, and other incidental costs. Insofar as the payments do, in fact, cover only these items, they can justly be seen as reducing a financial barrier and enhancing options for poor people.

In some cases, however, the "compensation" amount has been high enough to suggest a subterfuge to avoid anti-incentive reactions. Also, in some countries payments may serve to induce some individuals to have a sterilization who otherwise would not have done so. In this, of course, payments affect the poor disproportionately--a modest payment can be coercive to a person of limited means but innocuous to a wealthy person. The key question is: At what point does the acceptor's payment cease to be a relief from out-of-pocket costs and become an inducement? Drawing the line is difficult and must reflect the cultural and pecuniary conditions in each country. For example, an evaluation of the Sri Lankan incentives payments concluded that 500 rupees, about 8 percent of per capita income, or a month's wage for some acceptors, was not coercive, although higher

payments probably would be.

International donor agencies have had to grapple with this difficult issue. For example the policy of the US Agency for International Development (AID) states that "No AID funds can be used to pay potential acceptors of sterilization to induce their acceptance of voluntary sterilization." It notes, however, that reasonable compensation for time lost from work, transportation, food, and the like does not constitute an incentive.

Per-Case Payments to Health Personnel and Recruiters

Payments to providers "by the case" are common in several Asian countries; they can easily lead providers to promote contraception. Such tendencies are probably greatest with motivators, and with recruiters, who may act more like salespeople to bring in clients to collect a commission. In these cases "motivation" can easily lead to a "hard sell" approach, with diminished regard for informed consent or voluntarism. Per-case payments can be of particular concern where targets for health personnel or recruiters are established and individuals not meeting their targets are penalized.

Community Incentives

Insofar as they benefit communi- ties, providing needed funds for development activities without putting undue pressure on individuals, community incentives can be viewed as relatively nonrestrictive of personal freedom. However, when community members or their leaders apply strong pressure on individuals to have fewer children or to practice contraception

so that the community will be eligible for a reward, then these incentives can restrict free choice. Disincentives may also come into play; it would be unfortunate, for example, if a government were to withhold basic services as a punishment for low-performing communities. Thus, community measures may contain the seeds of coercion, and safeguards must be considered. It should be noted, however, that peer pressures flowing from the group consensus are the cultural norm in many Asian societies and may not be considered coercive by members of the community themselves.

Incentives for Small Families

In some cases, such as the long-term bond schemes practiced on the tea plantations of India or the educational bond experiment in Taiwan (province of China), incentives for small families served as a kind of old-age insurance and provided an alternative to children for support of elderly parents. They gave positive benefits to families and do not appear to have significantly restricted the individual's choice of family size. Where such economic benefits can be turned into penalties later on--for example, when loans made to small families must be repaid immediately by couples going beyond the agreed parity--then they are more restrictive of individual liberty.

Disincentives

Intended to penalize individuals who do not comply with governmental population policy, disincentives are meant to be harsher than the positive inducements examined earlier. On the whole, they restrict individual choice more than positive incentives do, although some are more

severe than others. For example, loss of a tax exemption after the nth child is less severe than loss of housing priority, if only because fewer people pay taxes. Disincentives would appear to be justified only after positive incentives have not succeeded and when a societal consensus exists on such means of reducing population growth.

Discussion

A new context has emerged for the discussion of funding methods for public programs. Cost pressures have increased at the same time that programs have grown; many developing countries are in worse financial straits than before. An argument can be made for consumers to carry a greater share of the costs, but other considerations, such as restraining population growth, argue in the opposite direction. It is fair to say that in the past many programs appeared to give little systematic thought to their structures of charges, payments, and incentives; their practices developed on an ad hoc basis, producing some of the diversity and inconsistencies seen in the present data.

Now both governments and donors are scrutinizing funding issues, including cost recovery on one side and stimuli to contraceptive use on the other. The following considerations are relevant to the current discussions.

Affordability to the user. Price elasticity is not known for contraceptives offered by public programs to poor populations, but the number of contraceptive users will presumably decline as the price per unit rises. Token charges may enhance the perceived value of the product and motivate the providing personnel if they keep a share, but the need for even

a little cash in hand can pose a real obstacle to purchasing contraceptives for impoverished villagers. The most affordable item is the free one; if affordability is a high priority, contraceptives should be provided free and exceptions should be made only for reasons that clearly outweigh the presumption of no charges.

Equity. The poor should have as ready access to vital services as those who are not poor. Free or subsidized services, as in social marketing programs, help achieve this. Some countries have in effect a dual system, providing contraceptives at a somewhat higher cost through the social security network or commercial outlets, but at lower cost through the Ministry of Health. Variations in dual systems deserve further thought; they may aid cost recovery and help cross- subsidization while still retaining equity and affordability.

Reimbursement justifications. In some circumstances, as where dire poverty exists, clients who accept sterilization and the IUD may be reimbursed for travel costs to a medical facility, time lost from work, extra foods, and so on. If the service is provided free, reimbursement removes a true cost obstacle. It requires greater public expense, but it increases both equity and affordability. Economic analyses over the years have shown a large net gain, even in the short run, from the investment of public funds in contraceptive services, an argument favoring cost reimbursements to clients in cases where out-of-pocket costs constitute a significant barrier to contraceptive use.

Incentive effects. In countries with anti-natalist policies, where incentives of one type or another are acceptable and feasible, the question arises as to their net cost to the government. Some incentive

measures are cost-free; indeed, some immediately save the government money, as with cancellation of tax exemptions, child allowances, and maternity leave for higher-order births. Others, such as direct payments for sterilization, constitute a budget outlay and increase program costs.[3] Countries employing the latter type of incentives have decided that the costs are offset by savings through reduced maternity and abortion care, fewer children to educate, and so forth, as well as other benefits to the society.

Critics of incentives and disincentives have not claimed that such approaches fail to yield net economic returns or that they fail to work. Rather, they argue that the measures are coercive or, citing the case of India during the emergency, are unacceptable to society. Such criticism has led, in at least one case, to the withdrawal of donor support. Reduced funding from international sources is, of course, a real cost, so that the ethical considerations carry over to objective cost calculations. In two instances, at least (Sri Lanka and Bangladesh), other controversies have focused simply on the amount of the payment, since if it is small enough it is no longer judged by the donor to be an incentive.

The availability of investment capital. While analysis may show sizeable net gains from investments devoted to making contraceptives free or offering payments to users, funds for the annual budget must still be found. All countries possess adequate capital to enrich a vigorous family planning program if that were the only need. The constraint is the long list of competing demands for limited resources. Here, donors can assist by improved analysis, country by country, of the flow of costs and savings from alternative financing schemes for programs.

Notes

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Incentive Score Changes Over Time. Lapham and Mauldin (1984, 1985) measured the use of incentives, without regard as to the amount, as one of the 30 scores they developed to assess the strength of program effort. This score ranged from 0 to 4 depending upon the number of parties who received a payment or other benefit linked to contraceptive acceptance: the client, any service personnel, the recruiter, or the community, and with extra credit for any disincentive that encouraged family planning or the small family. These scores were for the reference year 1982, and we have calculated comparable scores for 1987.

As regards the losses and gains over this five-year period, overall the movement is upward, with 11 countries increasing their score, and only two decreasing. The upward movement is sharpest in Asia, where 7 of 13 responding countries reported some strengthening as compared to only 4 of the 21 countries in the rest of the world.

Nineteen countries had scores of 0 in 1982; 15 of these remained at 0, and the other four moved only slightly upward. Thus there is

stability at the bottom. There is also stability among the few countries or economies at the top: of the three high-scoring ones in 1982, with scores of 3 or more, one moved further upward (Bangladesh) and two (Indonesia and Taiwan, province of China) remained the same. Furthermore, four countries moved sharply upward from lower levels: Korea, Pakistan, Liberia, and China, with Korea and China moving to the maximum score of 4.

2 The investigation by Lapham and Mauldin (1984, 1985) of the same 100 countries as in our study (those with over one million population) asked a few questions about social marketing programs, with a 1982 reference date. These questions were replicated in the 1987 questionnaire sent to the 100 countries (see text), and the scoring method on social marketing was repeated. Scores ranged from 0 to 4, depending mainly upon the percentage of the urban population covered by the social marketing program, since most such projects are directed to the urban population. Extra credit was also given if the program extended into the rural area.

Of 30 country questionnaires with usable information, 22 received identical scores in 1982 and 1987, nearly all at zero both times. The remainder were evenly balanced, with five receiving better scores and four receiving worse scores in 1987. This suggests little change in the global picture; however there are interesting cases on which we have little or no reliable information. These include Indonesia, which has just started an ambitious program with condoms, and Nigeria, Pakistan, and Ghana. Bangladesh stayed at a score of 4.0 over the period, and Nepal improved from 2.0 to 4.0. Egypt, which has an active social marketing program, fell slightly from 2.7 to 2.0. (There is, of course, a component of error in the

data, particularly because the respondents differed on the two dates.)

3 This applies to per-case payments to providers also, but in some countries these are used simply as a salary substitute and not as a staff incentive.

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Table 1 Charges and Payments to Contraceptive Acceptors, Public Sector

Region	Charge acceptor fees		Neither charge nor pay acceptors		Pay acceptors	
	Location	Methods provided[a]	Location	Methods provided[a]	Location	Methods provided[a]
Africa	Botswana	All	Burkina Faso	St		
	Burkina Faso	I,O,C,S	Chad	All		
			Ethiopia	All[b]		
			Liberia	All		
			Niger	All		
			Nigeria	All		
			Sudan	All		
			Togo	All		
			Zimbabwe	All		
Asia	Hong Kong	All	Bangladesh	O,In,C,S,D	Bangladesh	I,St
	Korea, Rep. of	I,O,C	China	All	India	I,St
	Pakistan	O,C,S	India	Ab	Korea, Rep. of[e]	St
	Sri Lanka	O,C	Indonesia	I,O,C,In	Nepal	St
	Taiwan, China	I,O,C,St	Korea, Rep. of	Ab[d]	Pakistan	St
	Thailand[c]	I,O,C,In,St	Nepal	I,O,C,S,D,In	Sri Lanka	St
	Singapore	All	Philippines	All		
			Sri Lanka	I,In		
Latin America	Peru[f]	All	Colombia	All		
			Costa Rica	All		
			Jamaica	All		
			Mexico	All		
			Paraguay	All		
Middle East	Jordan	I	Egypt	I,O,C,D,S		
	Turkey	St	Jordan	O		
			Morocco	I,O,C,St		
			Tunisia	I,O,C,S,St		
			Turkey	I,O,C,D		

a. Codes for methods are: I = IUD; O = orals; C = condoms; S = spermicides; D = diaphragm; In = injectables; St = sterilization (male and female); Ab = abortion.

b. Government program.

c. The Thailand program officially provides contraceptives free except injectables; however, in practice, many acceptors are charged.

d. Only menstrual regulation for low-income women.

e. Payment made only to low-income acceptors: US$330 to acceptors with one child, US$110 to acceptors with two children, and US$45 to acceptors with three or more children.

f. Ministry of Health. No charges in the Social Security system.

Table 2 Per-case Payments to Family Planning Personnel, 1987 or Most Recent Year

Region	No per-case payments	Per-case payments: Orals — Location	Orals — Providers[a]	IUD — Location	IUD — Providers[a]	Female sterilization — Location	Female sterilization — Providers[a]
Africa	Botswana Burkina Faso Burundi Cote d'Ivoire Ethiopia Liberia Mauritania Niger Nigeria Senegal Somalia Sudan Togo						
Asia	Burma China Hong Kong Laos Singapore Thailand	Philippines Taiwan, China Sri Lanka	M,N M,N,O N	Bangladesh Korea, Rep. of Nepal Philippines Taiwan, China	M,N,O M M,N M,N O	India Bangladesh Korea, Rep. of Nepal Philippines Taiwan, China Pakistan Sri Lanka	O M,N,O M M M,N O M,N,O M,N,O
Latin America and the Caribbean	Bolivia Brazil Chile Colombia El Salvador Mexico Panama Puerto Rico	Peru[b]	O	Peru[b]	O		
Middle East	Iraq Jordan Turkey	Egypt[c]	M,N,O	Egypt[c]	M,N,O		

a. Provider codes are: M = medical doctors; N = nurses and/or midwives; O = others.

b. IPPF affiliates (Instituto Peruano de Paternidad Responsable).

c. 1984 data.

Table 3 Social Marketing Prices (in US$), by Method

Region	Location (and Year)	Price in US$					
		Orals (one cycle)	Condoms (dozen)	Spermicide (per application)	Injectables	ORS[a] (one packet)	IUD
Africa	Egypt (1986)	.24	.28	.35			1.92
	Ghana (1987)	.11	.21	.01			
	Nigeria (1986)	.25	.60	.04			
Asia	Bangladesh (1986)	.05,.13	.08,.12,.15	.01	.32	.09	
	Hong Kong (1986)	.32	1.03	1.03,1.28			
	India (1985)	.12	.12,.19				
	Indonesia (1987)		.48				
	Malaysia (1986)	.32	.36		5.00		
	Nepal (1986)	.12	.28	.02		.05	
	Pakistan (1986)		.12				
	Sri Lanka (1985)	.09,.13	.18,.55	.32			
	Taiwan, China (1986)	.50	.38				
	Thailand (1985)	.19,.26,.33	.36,.48,.84				
Latin America and the Caribbean	Barbados (1984)	1.26	3.00				
	Bolivia (1986)	.25	.25				
	El Salvador (1985)	.40	1.36	.05			
	Guatemala (1985)	.61	2.08	.09			
	Honduras (1986)	.75	2.48				
	Jamaica (1987)	.18	.44				
	Mexico (1985)	.37	2.64,3.96,5.16		1.40		4.35
	Colombia (1986) (PROFAMILIA)	.20-.40	.48	.10			

Note: Two or more numbers in one cell denotes multiple brands.

a. Oral rehydration salts

Sources: Much of the above information is provided courtesy of the Social Marketing Forum, which regularly issues price data and made some figures available prior to publication. Data for 1984 and 1985 are from J. D. Sherris et al., Population Reports, Series J-30 (July-August 1985). Other information comes from the 1987 questionnaire described in the text.

Figure 1

Charges to Oral Contraceptive Acceptors

(per cycle), 1983-87

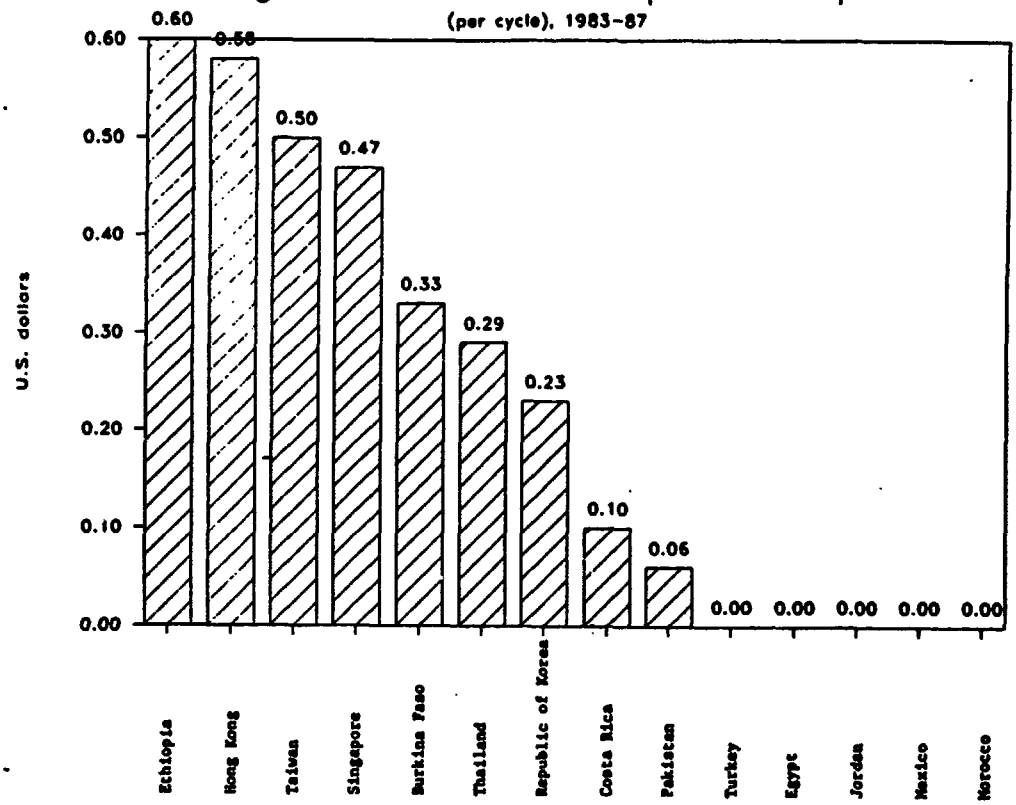


Figure 2

Charges and Payments to IUD Acceptors, 1983-87

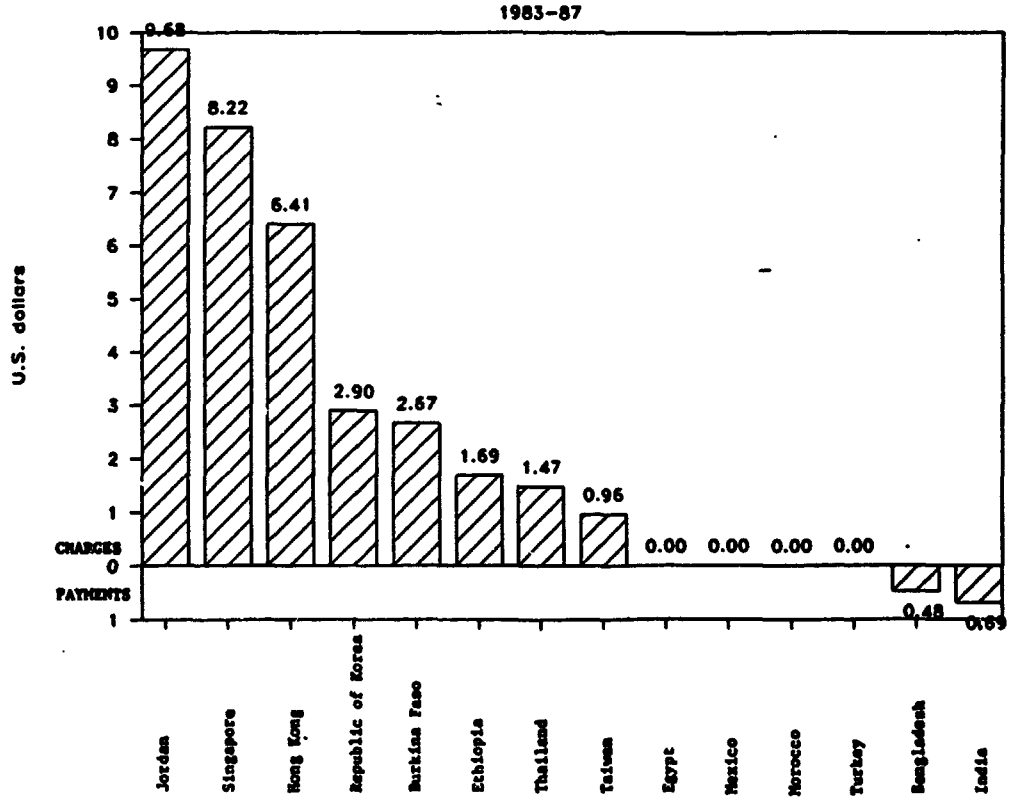


Figure 3

Charges, Payments, Female Sterilization

Acceptors, 1983-87

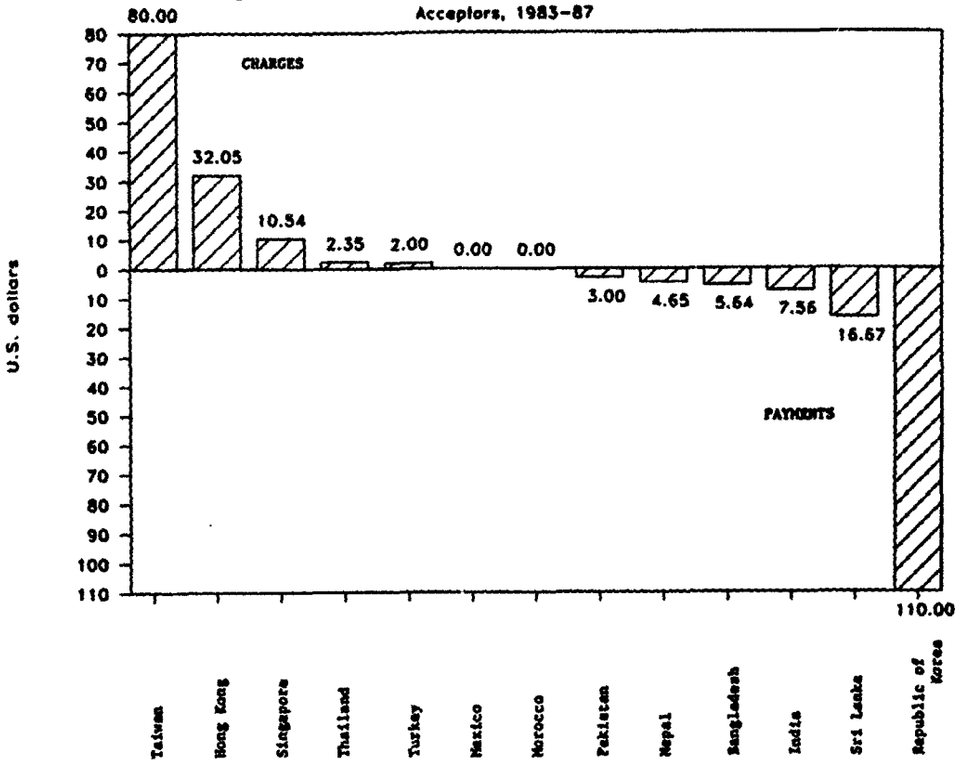


Figure 4

Minimum Price of Orals (per cycle),

Private Sector, 1987

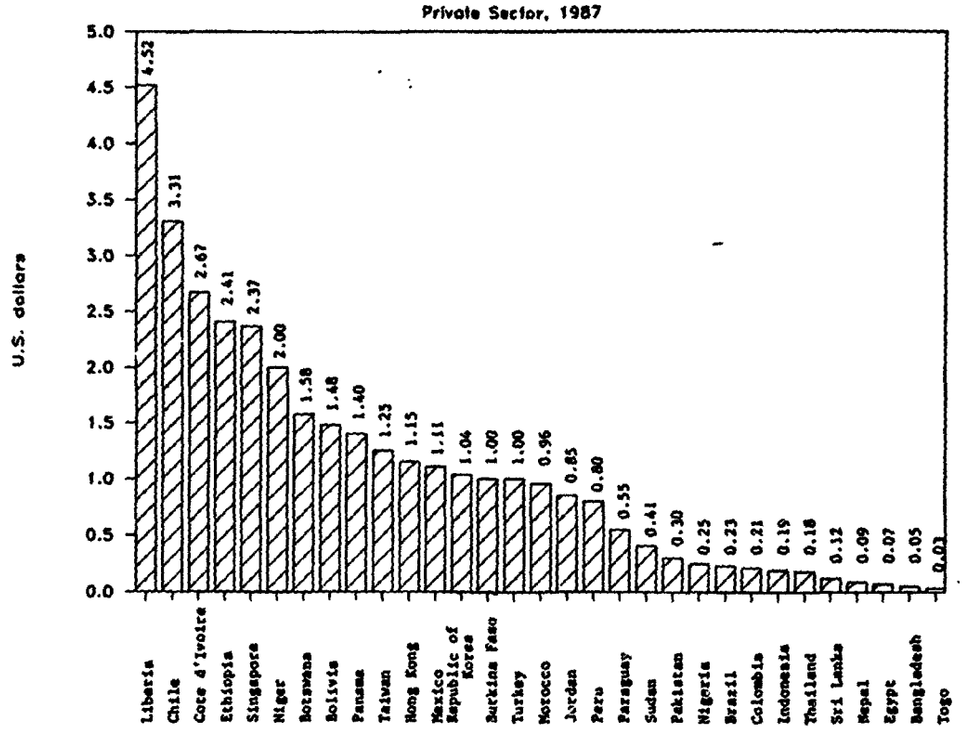


Figure 5

Minimum Price of IUDs,

Private Sector, 1987

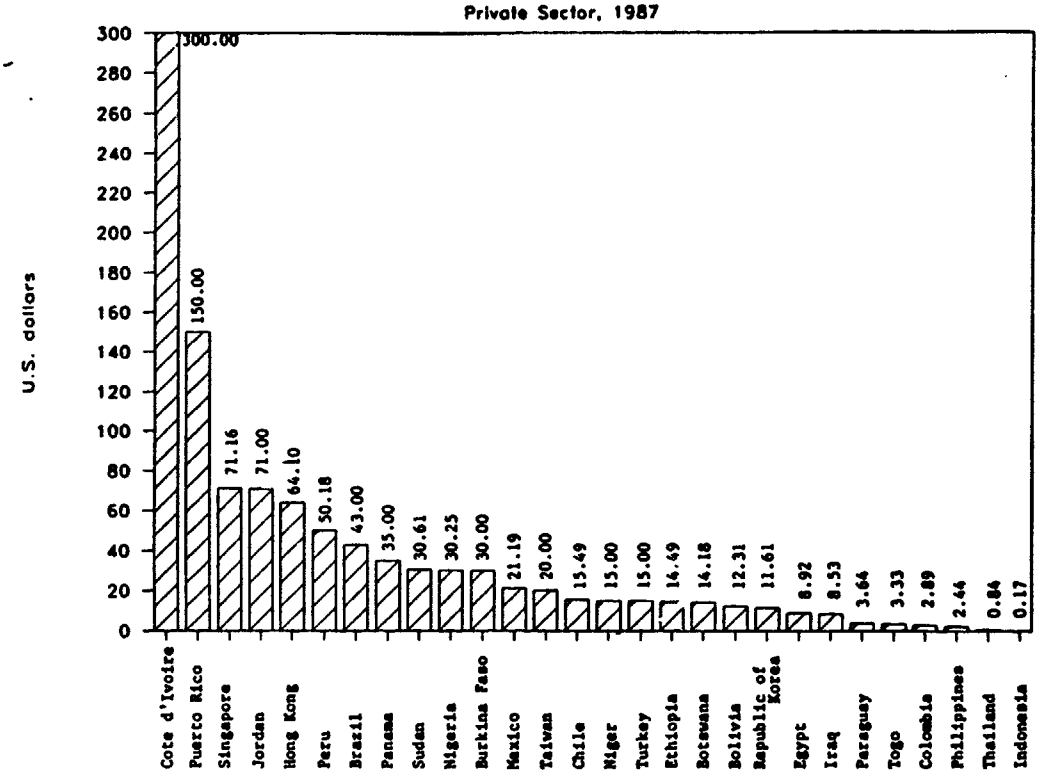
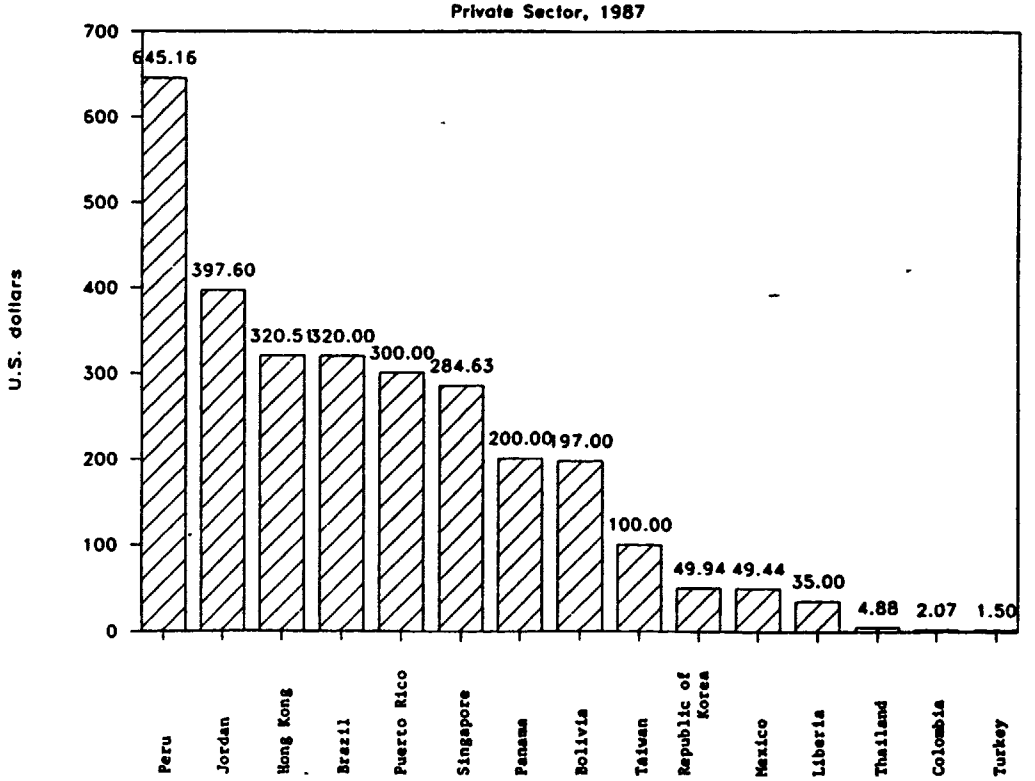


Figure 6

Minimum Price of Female Sterilization,

Private Sector, 1987



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